

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01340

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gardner</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gardner Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>County road 1 mile east of Gardner</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilmer</u> <u>Kenneth</u> <u>Ballard</u>				4. DATE OF DEATH Month Day Year <u>1</u> <u>9</u> <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 57</u>	9. AGE (In years last birthday) Yrs. <u>4</u> Mos. <u>11</u> Days <u>17</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wilmer Alonzo Ames</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ballard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Sarah Ballard</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho Pneumonia</u> DUE TO (b) <u>Cold + infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lapsed resistance - weight loss stationary for 2 months</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. E. Sartorius</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Smith</u>				24a. REC'D BY REGISTRAR <u>11/9/58</u>			
ADDRESS <u>4000 103rd St</u>				24b. REGISTRAR'S SIGNATURE <u>W. E. Sartorius</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED
JAN 14 1938
BUREAU V. S.

RECEIVED
JAN 14 1938
BUREAU V. S.

1349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City			
c. LENGTH OF STAY IN 1b 52 years				d. STREET ADDRESS RFD #3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PAUL T. BARNES			4. DATE OF DEATH Month January Day 16 Year 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1872		9. AGE (In years lost birthday) yrs. 85	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Barnes				14. MOTHER'S MAIDEN NAME Virginia Lankford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Robert Scott, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Chronic Myocarditis							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 16, 1958 , to Jan 16, 1958 , that I last saw the deceased alive on Jan 16, 1958 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE C. E. Critcher M.D.				PHYSICIAN'S NAME (Type) C. E. CRITCHER, M.D. New Church, Virginia			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-58		22c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		22d. LOCATION (City, town, or county) (State) Rural-Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson				24a. REC'D BY REGISTRAR DATE JAN 21 '58		24b. REGISTRAR'S SIGNATURE Paul H. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

BUREAU V. 2

JAN 21 1938

RECEIVED

1350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN lb <u>80 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>Harry S. Bowen</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>1958</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>March 29 - 1877</u>		9. AGE (In years last birthday) <u>80 9/25</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTH PLACE (State or foreign country) <u>Snow Hill, md</u>		
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Charles H. Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kemman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mattie W. Bowen, Snow Hill, md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Tongue</u> 141.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)		
21. I certify that I attended the deceased from <u>Dec 6</u> , 19 <u>55</u> , to <u>Jan 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Snow Hill, md</u> DATE SIGNED <u>Jan 24 1958</u>						
ACTUAL SIGNATURE <u>Paul C. Jones</u> M.D. <u>Snow Hill, md</u>						
PHYSICIAN'S NAME (Type) <u>P. C. Jones</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bates Methodist</u>		
22d. LOCATION (City, town or county)		22e. (State)		22f. (Country)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis</u>		ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u>		
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>						

VS A1S (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 15

BUREAU V. N.

JAN 28 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01343

1351

Item 7 FilmG225 2-7-58 et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Md b. COUNTY WOR	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) West Ocean City		d. STREET ADDRESS West Ocean City	
3. NAME OF DECEASED (Type or print) Thomas — Cherry		4. DATE OF DEATH JAN 25 1958	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Cherry		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 24-32-5703	
17. INFORMANT Mrs Jenny Adkins Cherry		Address Ocean City Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410x DIETHEATED / PENDING / Autopsy DUE TO Acute dilatation of heart Conditions, if any, which gave rise to immediate cause (b) Mitral Insufficiency (c) Myocardial Hypertrophy DUE TO Myocardial Hypertrophy			INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 yrs. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Francis J. Townsend Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Francis J. Townsend Jr		DATE SIGNED JAN 28, 58.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/2/1958	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR FEB 4 '58	24b. REGISTRAR'S SIGNATURE Aw. Smith

MEDICAL CERTIFICATION

WEST VIRGINIA STATE DEPT. OF HEALTH - MARTINSBURG 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

FEB 3 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

01344

1352

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>78 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 JEFFERSON</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HORACE O. CROPPER</u>		4. DATE OF DEATH Month Day Year <u>JAN 11 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE OR. REAL ESTATE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES P. CROPPER</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE ZULLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES SPAN. AMER.</u>		16. SOCIAL SECURITY NO. <u>214-32-727</u>	
17. INFORMANT <u>MR JACK FARLOW</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy sec Arteriosclerosis Sen</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus. Degenerative</u> DUE TO (c) <u>Myocarditis - Degeneration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>15 yrs</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, severe; Lic. Dolores Blotus by</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>58</u> , to <u>Jan 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>58</u> , and that death occurred at <u>12:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harman G. Robbins</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Harman A. Robbins M.D.</u>		<u>Berlin, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH-BUFFALO, 19

IAN 15 1963

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MD c. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS PHILADELPHIA AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First IRMA Middle S. Last CROPPER		4. DATE OF DEATH Month JAN. Day 30 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1906
9. AGE (In years last birthday) 51 yrs		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK TYRE		14. MOTHER'S MAIDEN NAME ELIZABETH TIMMONS.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) - (If yes, give war or dates of service)		16. SOCIAL SECURITY NO -	
17. INFORMANT MRS. EVELYN AIKIN		Address OCEAN CITY MD	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 572X DUE TO Chronic nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 weeks (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 56 to Jan 30, 1958 , that I last saw the deceased alive on Jan 30, 1958 , and that death occurred at 3:50 P M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Ocean City Md. DATE SIGNED FEB 1, 58	
ACTUAL SIGNATURE F. J. Townsend, Jr. M.D.			
PHYSICIAN'S NAME (Type) F. J. Townsend, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-2-58	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN	22d. LOCATION (City, town, or county) (State) BERLIN MD.
23 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE FEB 3 58		P. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register, prior to burial, cremation, removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1354

CERTIFICATE OF DEATH

Reg. Dist. No.

01346

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Berlin c. LENGTH OF STAY IN 1b Rural, Berlin d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Berlin d. STREET ADDRESS Route # 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Cutler Last		4. DATE OF DEATH Month 1 Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1895 9. AGE (In years last birthday) 62 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-5895	
17. INFORMANT Mrs. Pauline Purnell, Berlin Md, Route #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertensive Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/29, 1957 , to 12/17, 1957 , that I last saw the deceased alive on 12/17, 1957 , and that death occurred at 2 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory W. Sily, Jr. M.D.		DATE SIGNED 1/7/58	
PHYSICIAN'S NAME (Type) Ivory W. Sily, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-8-1958	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Md
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE 11-58	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 13 1953
BUREAU V. S.

1355

CERTIFICATE OF DEATH

Reg. Dist. No.

01347

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>				c. LENGTH OF STAY IN 1b <i>60 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Della</i> Middle <i>L.</i> Last <i>Evans</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>11</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 2 - 1879</i>	
9. AGE in years (last birthday) <i>78 5/9</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>10</i> Hours <i>15</i> Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13. FATHER'S NAME <i>John Hales</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>md Frank Evans</i> Address <i>Snow Hill, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 Hrs</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> <i>10 yrs</i>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>1950</i> 19 to <i>1-11-58</i> 19 that I last saw the deceased alive on <i>1-11-58</i> 19 and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert C. Lamar</i> M.D.				ADDRESS (Street, city or town, state) <i>104 B B St</i> DATE SIGNED <i>1/13/58</i>			
PHYSICIAN'S NAME (Type) <i>ROBERT C. LAMAR</i>				<i>Snow Hill, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Jan. 14/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baton Methodist Church</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill, md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray B. Evans</i> ADDRESS <i>Snow Hill, md</i>				24a. REC'D BY REGISTRAR <i>Alfred</i> DATE <i>JAN 15 '58</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1971 - 1978

BUREAU V. 11

1356 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RED #2		d. STREET ADDRESS Leemont	
3. NAME OF DECEASED (Type or print) First BERTHA Middle G. Last GARRETT		4. DATE OF DEATH Month January Day 31 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Germroth		14. MOTHER'S MAIDEN NAME Ella Bishop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 65-05-8204	
17. INFORMANT Rev. C.C. Garrett, Leemont, Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic Nephritis. DUE TO (c) Chronic Glomerular Nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural Effusion of Undetermined Origin		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 27, 1958 to Jan. 31, 1958 , that I last saw the deceased alive on Jan. 31, 1958 , and that death occurred at 7:00 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles W. Trafer M.D. 302 Market Street 2-1-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles W. Trafer, M.D. Pocomoke City, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIED	22b. DATE THEREOF 2-5-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	22d. LOCATION (City, town, or county) (State) Drexel Hill, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Henry L. Watson		24a. REC'D BY REGISTRAR 2-5-58	
ADDRESS Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE Deborah	

MEDICAL CERTIFICATION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FB 3 1 8

RECEIVED

1357 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RTD #3</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>F.</u> Last <u>GOOTEE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1898</u>		9. AGE (In years last birthday) <u>59</u> yrs	10. IF UNDER 1 YEAR: Months <u>30</u> Days <u>30</u> Hours <u>15</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John G. Gootee</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Lee Timmons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>217-36-1014</u>		17. INFORMANT <u>Mrs. Milton A. Payne, Pocomoke, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Larynx</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>approx 8 Mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 1, 1957</u> to <u>Jan. 30, 1958</u> , that I last saw the deceased alive on <u>Jan. 29, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles W. Trader</u>				ADDRESS (Street, city or town, state) <u>302 Market St., Pocomoke City, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles W. Trader,</u>				DATE SIGNED <u>1-31-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR INTERMENT		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-2-58</u>		<u>Remson Methodist</u>		<u>Rural Pocomoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Stinson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED
JAN 10 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1358

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution/Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Box 100</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Hearne</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30 1918</u> 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Evelyn</u>		14. MOTHER'S MAIDEN NAME <u>Lola Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-1678</u>	
17. INFORMANT <u>Wm Hearne (Husband)</u> Address <u>Girdletree Rd Routed</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhages</u> DUE TO (b) <u>Star wounds of chest + cent throat</u> DUE TO (c) <u>Star wounds of chest + cent throat</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>"Attempted Rape" (7)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I and Part II of item 18.) <u>3 negro men attacked her while she was alone on her back at her store. They held her down and stabbed her and cut her throat.</u>	
20c. TIME OF INJURY Month, Day, Year <u>Jan 16 1958</u> Hour <u>10 a.m.</u> Minute <u>15</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Husband's store</u>	
20e. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20f. (City or town) <u>Box 100</u> (County) <u>Worcester</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried Jan 19 1958</u>		22b. DATE THEREOF <u>Jan 19 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christian Unity</u>		22d. LOCATION (City, town, or county) <u>Snow Hill</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Smith</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>JAN 20 1958</u> 24b. REGISTRAR'S SIGNATURE <u>J. E. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1359

CERTIFICATE OF DEATH

Reg. Dist. No. 01351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J.</u> Last <u>Mason</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 - 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beloved Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomac, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dennis Mason</u>		14. MOTHER'S MAIDEN NAME <u>Clara Pullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Frank S. Mason</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic</u> DUE TO <u>Cardio-vascular renal disease</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>54 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-18-58</u> , 19 <u>58</u> , to <u>1-19-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-19-58</u> , 19 <u>58</u> , and that death occurred at <u>Foot</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u>		ADDRESS (Street, city or town, state) <u>Snow Hill, md</u>	
PHYSICIAN'S NAME (Type) <u>Paul Cohen</u>		DATE SIGNED <u>1-21-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>660 Springdale Cemetery</u>	22d. LOCATION (City, town, county) (State) <u>Budapest, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Dunning</u>		24a. REC'D BY REGISTRAR <u>W. E. Dunning</u>	
ADDRESS <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Dunning</u>	

BUREAU V. S.

N 1578

RECEIVED

1360

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOHN S. McALLISTER</u>				4. DATE OF DEATH Month Day Year <u>January 4 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 13, 1873</u>		9. AGE (In years last birthday) yrs. <u>84</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph McAllister</u>				14. MOTHER'S MAIDEN NAME <u>Julia Briddell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Nellie M. McAllister, Pocomoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>ATHEROSCLEROTIC VASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>10 YEARS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>POCOMOKE WORCESTER MD.</u>		20f. (City or town) (County) (State) <u>POCOMOKE WORCESTER MD.</u>	
21. I certify that I attended the deceased from <u>DEC. 1</u> , 19 <u>55</u> , to <u>JAN 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 4</u> , 19 <u>58</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>212 MARKET ST. 1-6-58</u> ACTUAL SIGNATURE <u>C. S. Hamilton</u> M.D. PHYSICIAN'S NAME (Type) <u>C. S. HAMILTON</u> <u>POCOMOKE CITY, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-58</u>		22c. NAME OF CEMETERY <u>Bethany Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Henry D. Watson</u> <u>Pocomoke, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 58</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JAN 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01353

1361

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>POCOMOKE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>POCOMOKE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke City</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD #3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MITIE</u> Middle <u>G.</u> Last <u>CUTTEN</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1967</u>
9. AGE (In years last birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>15</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen D. Redden</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Pilchard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Mellon Trader, Pocomoke City, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Degenerative Heart Disease</u> DUE TO (c) <u>Degenerative Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1949</u> to <u>Jan. 15, 1958</u> that I last saw the deceased alive on <u>Jan. 10, 1958</u> , and that death occurred at <u>6:30 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>302 Market St., Pocomoke City, Md.</u> DATE SIGNED <u>1-16-58</u>			
ACTUAL SIGNATURE <u>Charles W. Trader</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles W. Trader, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-18-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cutten Family Cemetery Rural Pocomoke City, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>P.O. Box 100, Pocomoke City, Md.</u>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 20 1958

BUREAU V. S.

VS A15 (4)
15M 9/55

Reg. Dist. No. 01354

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MANNIE</u> Middle <u>HESTER</u> Last <u>PARSONS</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEWARK MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES EDWARD DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>MAHALA PURNELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>MRS HALLIE COSTOPLOS</u>		Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>5 Jan 1958</u> to <u>5 Jan 1958</u> , that I last saw the deceased alive on <u>5 Jan 1958</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ocean City, MD</u> DATE SIGNED <u>Jan 8 1958</u> ACTUAL SIGNATURE <u>Dr. Thomas</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>N. P. THOMAS</u> <u>OCEAN CITY MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Surbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

JAN 18 1938

RECEIVED

1363

CERTIFICATE OF DEATH

01355

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u> c. LENGTH OF STAY IN 1b <u>11 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Shelbert H. Ramsay Jr.</u> First Middle Last		4 DATE OF DEATH <u>Jan. 1 1958</u> Month Day Year	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 22 1896</u> Year
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Body Painter</u>		11. KIND OF BUSINESS OR INDUSTRY <u>General Trucking</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. BIRTHPLACE (State or foreign country) <u>Seward, Nebraska</u>	
13. FATHER'S NAME <u>Shelby Ramsay</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Dickman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give number and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>506-03-6039</u>	
17. INFORMANT <u>Shelbert H. Ramsay Jr.</u> Address <u>Snow Hill, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>1/1/58</u> , 19____, that I last saw the deceased alive on <u>11/26/57</u> , 19____, and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Snow Hill, md</u>		DATE SIGNED <u>1/2/58</u>	
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.		PHYSICIAN'S NAME (Type) <u>DR. PAUL COHEN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 4 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May B. Morris</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>Jan 6</u> 24b. REGISTRAR'S SIGNATURE <u>A. H. Duck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A 01

1364

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>MD</u> c. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 BAKER ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE TOWNSEND RICHARDSON</u>				4. DATE OF DEATH Month Day Year <u>JAN 15 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 2, 1859</u>	9. AGE (In years last birthday) <u>98</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. P. OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>SNOW HILL MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>MARIA HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>		17. INFORMANT <u>MRS RALPH BRITTINGHAM</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interoschrotic C-V renal disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1957</u> to <u>15 Jan 1958</u> , that I last saw the deceased alive on <u>15 Jan 1958</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>Ocean City, Md</u> DATE SIGNED <u>17 Jan 58</u>			
PHYSICIAN'S NAME (Type) <u>W. S. Thomas</u>				ADDRESS <u>Ocean City, Md</u> DATE SIGNED <u>17 Jan 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEWMARK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Budge Berlin Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

25

RECEIVED

1365

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	c. LENGTH OF STAY IN 1b <u>89 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 MAIN ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RYDIE</u> Middle <u>M. T.</u> Last <u>RIDINGS</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8, 1868</u> 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>
13. FATHER'S NAME <u>JAMES MAC GREGOR</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH POWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT Address <u>MRS. WALTER MURPHY, BERLIN MD</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Rectum</u> DUE TO <u>Metastasis of</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis & Coronary</u> DUE TO <u>Arteriosclerosis & Coronary</u> (c) <u>Arteriosclerosis & Coronary</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 mo</u> <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis, Vascular Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>4 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 Jan</u> , 19 <u>58</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert A. Robbins, M.D.</u>		ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>1/6/58</u>	
PHYSICIAN'S NAME (Type) <u>Herbert A. Robbins, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit form. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AN 9 1958

BUREAU V. S.

1366

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Millersville Landing Road		d. STREET ADDRESS Rt # 1	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND Keith ROBERTSON		4. DATE OF DEATH Month Day Year January 3 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1919
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md. Dep. Forrests		10b. KIND OF BUSINESS OR INDUSTRY Ass't Dist. Forester	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Robertson		14. MOTHER'S MAIDEN NAME Mae Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mrs. Lola Robertson, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 30 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) POCOMOKE CITY WORCESTER MD.	
21. I certify that I attended the deceased from JAN. 3, 1958 to JAN 3, 1958 , that I last saw the deceased alive on JAN 3, 1958 , and that death occurred at 7:23 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 212 MARKET ST. 1-3-58			
ACTUAL SIGNATURE C. Stanford Hamilton M.D.		DATE SIGNED 212 MARKET ST. 1-3-58	
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON		POCOMOKE CITY MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/58	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Storm Lake, Iowa
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.		24a. REC'D BY REGISTRAR JAN 7 58	
24b. REGISTRAR'S SIGNATURE Norman Baker			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1900



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01359

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton-Rural</u> c. LENGTH OF STAY IN lb <u>4 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 R. 28</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton-Rural</u> d. STREET ADDRESS <u>1 R. 28</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Spencer</u> Middle <u>Spencer</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 12 - 1898</u>		9. AGE (In years last birthday) <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Jenny Backett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-206925</u>		17. INFORMANT <u>Malinda Fillett Sister</u> Address <u>Snow Hill MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiectasis</u> <u>Probably</u> <u>526x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>C. Bronchitis</u> (c) <u>Repatized - Arteriosclerosis heart disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatigue from a hunting trip a few days before</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/6/58</u>			
22a. FULL CREMATION, REMOVAL (Specify) <u>Jan. 10/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Leighton's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Secombe City Road</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Sartorius</u> Address <u>Snow Hill, MD</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	
DATE <u>JAN 13 '58</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, indicating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

BUREAU V. S.

AN 13 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01360

1347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City d.</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.F.D. 13</u>			
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>Spratley</u> Last				4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>March 2, 1890</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jan. 58</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Surry Co. Va.</u>			
13. FATHER'S NAME <u>Walter Spratley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>War 1 231 12 3561</u>		17. INFORMANT <u>John Strand</u> Address <u>Accomac, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan. 24, 1958</u>			
EXAMINER'S NAME (Type) <u>H.E. Sartorius, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>R.F. Spratton Memorial</u>			
22d. LOCATION (City, town, or county) <u>Pocomoke</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>		ADDRESS <u>Accomac, Va.</u>		24a. RECEIVED BY REGISTRAR <u>Jan 24 1958</u>			
24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>		DATE					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

BUREAU V. M.

1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1363 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film G225 2-13-58 et

Reg. Dist. No. 01361

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u> c. LENGTH OF STAY IN 1b <u>5 yrs +</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1703</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> d. STREET ADDRESS <u>1703</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Andrew George Washington</u> First Middle Last				4. DATE OF DEATH <u>Jan 28</u> 19 <u>58</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 1st</u> <u>1880</u> <u>Unknown</u> <u>yr.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Whitey helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>(?)</u>		17. INFORMANT <u>Rachael Newton - RRA3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>(Probably) Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>minutes before</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lived in untenable down quarters, on 4th quarter in dest. poor & semi-</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury seen</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. E. Sartorius Sr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/29/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cem</u>		22d. LOCATION (City, town, or county) <u>Berlin</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR <u>DATE FEB 3 '58</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Arch...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF OHIO
MEDICAL EXAMINER
CERTIFICATE OF DEATH

BUREAU V. 2

EB 3 1958

RECEIVED

1369

CERTIFICATE OF DEATH

01362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Horseester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Horseester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green City, Md</u>		c. LENGTH OF STAY IN 1b <u>70 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lloyd Thomas Williams</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>25</u> - Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Marine Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Oswald Williams</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Horasky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-164986</u>	
17. INHERITANT <u>Mrs. H. J. Williams</u>		Address <u>Green City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 25, 1953</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 25, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. R. Thomas</u> M.D.		DATE SIGNED <u>25 Jan 58</u>	
PHYSICIAN'S NAME (Type) <u>N. J. Thomas</u>		ADDRESS (Street, city or town, state) <u>Green City, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>D. T. George</u>		22d. LOCATION (City, town, or county) (State) <u>Green City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Williams</u> ADDRESS <u>Green City, Md</u>		24a. RECEIVED BY REGISTRAR <u>W. J. Thomas</u> DATE <u>25 Jan 58</u>	
		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

14N 57 1938

RECEIVED